ATTACHMENT I SCOPE OF WORK AND LME ESSENTIAL ELEMENTS

The Contractor shall perform all Local Management Entity (LME) functions as outlined in the Local Business Plan and in accordance with DHHS requirements. The functions include:

- (1) General Administration and Governance
- (2) Business Management and Accounting
- (3) Information Management Analysis and Reporting
- (4) Claims Processing
- (5) Provider Relations and Support
- (6) Access, Screening, Triage and Referral
- (7) Service Management (Utilization Management, Service Coordination and Community Collaboration)
- (8) Consumer Affairs and Customer Services (including Community Collaboration)
- (9) Quality Improvement and Outcomes Evaluation.

1.0 General Administration and Governance

1.1 Catchment Area Population Size

The population in the Contractor's catchment area shall be at least 200,000 people unless a waiver is granted in writing from DHHS.

1.2 Governance Authority

The Contractor shall be a governance entity that meets North Carolina General Statute 122-C as amended and has the written support of the county Board(s) of County Commissioners for the area served.

1.3 Consumer and Family Advisory Council

The Contractor shall develop and maintain a Consumer Family Advisory Committee (CFAC) for the purpose of providing input to the Contractor on policy issues consistent with the State Plan. CFAC meetings shall be convened at least monthly and shall be open to the public. The Contractor shall develop a relational agreement with the CFAC in accordance with the guidelines outlined in Attachment III-2.

1.4 Structural Capacity and Competency

The Contractor shall have an administrative and organizational structure adequate to manage the essential functions described in this contract. That structure and the administrative practices of the Contractor shall be available in a Policy and Procedure Manual written in a format and style that complies with DHHS rules and

requirements and all applicable State and federal laws and regulations. The Contractor shall post all approved policies and procedures on the Contractor's website.

The Contractor shall maintain an organization with personnel sufficient to carry out the requirements of this contract and the duties of a County/Area Authority, as outlined in Part 2 of G. S. 122C, and shall minimally employ a chief executive (Area Director), a finance director and a medical/clinical director. The Contractor shall ensure that all staff has the training, education, experience, licensing, or certification appropriate to their position and responsibilities.

1.5 Chief Executive Officer (Area Director)

The Contractor's chief executive shall meet the minimum qualifications outlined in G. S. 122C-121, unless a specific waiver is granted by DHHS. The Contractor's Board shall evaluate the performance of the chief executive at least annually. The evaluation shall, at minimum, address the executive's performance in the following functional areas:

- (1) Maintaining an effective relationship with the Board of Directors
- (2) Developing and maintaining effective relationships within the community served and with local and State governmental officials
- (3) Encouraging consumer/family participation in service planning and delivery and encouraging the development of consumer-run businesses
- (4) Managing human resources
- (5) Fiscal Management and Performance
- (6) Demonstration of Leadership Skills

1.6 Strategic Planning

The Contractor shall develop a three-year strategic plan and update it annually. At a minimum, the strategic plan shall include:

- (1) Mission, vision and values statements;
- (2) Description of the organization and its structure;
- (3) Identification of internal, external and ultimate customers;
- (4) Analysis of strengths, weaknesses, opportunities and threats (SWOT analysis) based in part upon quality assurance data and a needs assessment of the catchment area;
- (5) Performance goals and objectives for the upcoming year;
- (6) Products and milestones to be achieved during the period covered by the plan;
- (7) Plans and strategies to transition persons currently in service who do not meet "target population" criteria to other community resources;
- (8) Plans for continuing to develop a system of community and natural resources to support members of the target and non-target populations;

- (9) Plans for continuous development of community capacity;
- (10) Plans to reduce reliance on State facility services and to comply with the DHHS bed-day allocation plan and bed closure timeframes;
- (11) Plans to continue to divest of direct service delivery, if applicable;
- (12) Plans for continuing competency development in the provider network;
- (14) Plans for implementation of best practice protocols;
- (15) Plans to increase opportunities for consumer involvement;
- (16) Plans to address delivery of mh/dd/sa services in time of disaster, including natural disasters, acts of war or terrorism, and medical epidemics;
- (17) Mechanisms for regular review of strategic performance and reporting to the Contractor Board and Stakeholders; and
- (18) Strategies for continuously improving the quality of the service system and increasing customer satisfaction.

The plan should include information on the person responsible for producing each deliverable and the expected date of completion. The written strategic plan shall be reviewed annually and updated as needed, taking into consideration stakeholder and community input. The Contractor shall provide evidence of consumer and family involvement and the full, active participation of the Consumer and Family Advisory Council (CFAC). The CFAC shall provide written evidence of its review and participation in the development of the plan and a statement of any concerns relative to the plan. The Contractor shall provide evidence that it has addressed these concerns.

The DHHS certified LBP, including DHHS provisions of certification, shall serve as the initial strategic plan and is included as Attachment III-3 of this Contract.

1.7 National Accreditation

By the conclusion of the Contractor's first three-year LBP certification cycle, the Contractor shall achieve national accreditation from a national accrediting body under behavioral healthcare standards. Accreditation shall be earned from the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO), the National Committee on Quality Assurance (NCQA), the Center for the Accreditation of Rehabilitation Facilities (CARF), or other organization as approved by DHHS.

1.8 Accreditation for Direct Services

If the Contractor has been approved through a waiver to continue to provide direct services to consumers, the Contractor shall maintain service delivery accreditation status from the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), Council on Accreditation (COA), Council on Accreditation of Rehabilitation Facilities (CARF), or the Council on Quality and Leadership in addition to the accreditation required in Section 1.6.

2.0 Business Management and Accounting

2.1 Financial Management Plan

The Contract shall comply with all aspects of G. S. 159, the Local Government Finance Act. In addition, the Contractor shall have a financial management plan that assures proper internal controls throughout the organization and the Qualified Provider Network (QPN). The plan defines:

- (1) Separation of duties;
- (2) Access to resources;
- (3) Systems of service and payment authorization;
- (4) Contracts management;
- (5) Record keeping for assets, liabilities, revenues and expenditures;
- (6) Retention and training of qualified personnel;
- (7) Understanding and compliance with applicable State and federal fiscal requirements:
- (12) Provision for an adequate audit trail, a policy and procedure defining payroll processes and an assessment to determine if internal controls are effective.

2.2 Budgeting and Financial Reporting

The Contractor shall have a policy and procedure for developing and managing a service budgeting process that includes tracking QPN payments against the budget, re-budgeting resources to the target population and re-investing savings realized thorough movements from restrictive, high cost care to lower cost alternatives.

2.3 Purchasing and Procurement

The Contractor shall have written policies and procedures governing purchasing and procurement, including policies and procedures for issuing Requests for Proposals (RFP) and Requests for Information (RFI) and the circumstances under which sole source procurement is permitted.

The Contractor shall maintain a listing of all real property transactions, stipulating the property purchase price, the percentage of State participation, and information on the sale and distribution of proceeds on properties disposed.

2.4 Contract Management

The Contractor shall have a policy and procedure that conforms to requirements outlined in this document and that stipulates parameters for negotiating and managing contracts with the QPN. The Contractor shall determine for all contractual relationships whether the contract represents a purchase of service or financial assistance contract. The Contractor shall monitor the performance of any

subcontracted provider operating under a financial assistance contract in accordance with the requirements of OMB Circular A-133.

2.5 Compliance with Regulation

The Contractor shall comply with the provisions of Attachment IV and the financing rules of this contract.

3.0 Information Management, Analysis and Reporting

3.1 Real Time Data

The Contractor shall have a comprehensive management information system to collect and analyze data in real time. The Contractor's data systems shall link to the access, referral and triage function and to providers within the QPN.

3.2 Reporting and Data Collection

The Contractor shall be in compliance with the Integrated Payment and Reporting System (IPRS) and the Medicaid Management Information System (MMIS) requirements. The Contractor shall successfully meet all system test requirements established by DHHS. After completion of all the test requirements, the Contractor's MIS system shall be certified as operationally ready by DHHS.

The Contractor shall submit data to the Consumer Data Warehouse (CDW) in the format and the timeframes specified by the DHHS.

Service utilization/encounter data containing detail for each consumer service provided by the Contractor shall be submitted at least monthly in an electronic format specified by DHHS.

Any changes in reporting requirements will be communicated to the Contractor at least 90 days before they are effective unless State or federal law requires otherwise.

Timeliness in submitting required reports and their accuracy will be monitored by the DHHS for compliance. Failure to report may be considered a material breach of this contract. The Contractor shall certify the accuracy of the data.

3.3 Information Systems Capacity and Competency

The Contractor shall maintain an information system sufficient to collect, analyze, integrate and report data that supports the following:

- (1) Consumer registration and demographic information
- (2) Provider enrollment and disenrollment

- (3) Third party liability
- (4) Claims payment and tracking
- (5) Consumer and provider grievance, appeals and complaint
- (6) Tracking and analyzing services and costs by population group and special needs categories
- (7) Encounter and demographic data reporting
- (8) Quality indicator reporting
- (9) HIPAA compliance
- (10) Consumer access, outcome and satisfaction
- (11) Utilization management authorizations and review

3.4 HIPAA

The Contractor shall comply with the Administrative Simplification requirements of Subpart F of the HIPAA of 1996 (Public Law 107-191, 110 Statutes 1936) and all federal regulations implementing that Subpart that are applicable to the operations of the Contractor by the dates required by the implementing federal regulations.

4.0 Claims Processing

4.1 Billing and Claims Processing

The Contractor shall have a policy and procedure that requires each provider billing through the LME to submit claims for covered services. Claims shall be submitted to the Contractor at least monthly, and on a schedule as may be provided by DHHS in written notices from DHHS to the Contractor.

The Contractor shall honor provider billings as long as they are filed in time to meet DHHS billing requirements. For Medicaid services, billings will be honored for up to twelve (12) months from the data of service. For services covered by funds allocated by the DMH/DD/SAS, billings shall be honored in accordance with the IPRS timely filing provisions.

The Contractor will pay claims in accordance with the Division of Mental Health, Developmental Disabilities and Substance Abuse prompt pay requirements set forth as follows: within eighteen (18) calendar days after the Contractor receives a claim from a provider, the Contractor shall either (a) approve payment of the claim, (b) deny payment of the claim, or (c) determine that additional information is required for making an approval or denial. If the Contractor approves payment, the claim shall be paid within (30) calendar days after making approval.

The Contractor shall disallow claims in the event and to the extent the claim is incomplete, does not conform to the applicable service authorization, or is otherwise incorrect. Any claim disallowed shall be returned to the provider with an explanation for the disallowance. The Contractor shall allow providers to re-submit a disallowed billing for re-consideration, so long as the re-submission occurs within the general

claims filing timeframes outlined above. The Contractor shall cooperate with its Providers in the prompt reconciliation of disallowed billings.

The Contractor shall not pay claims submitted after the time period allowed by DHHS billing requirements.

All payments for services to providers shall be provisional and subject to review and audit for their conformity with DHHS requirements and of any applicable subcontract.

The Contractor claims payment system, as well as its prior authorization and concurrent review process shall minimize the likelihood of having to recoup already paid claims. Any recoupment in excess of \$50,000 per provider within a contract year shall be approved in advance by DHHS.

The Contractor and its providers shall not charge or receive any payment from an eligible Medicaid person for covered services except for co-payments and sums payable by third party payers under coordination of benefits provisions.

4.2 Reimbursement

The Contractor shall coordinate benefits so that costs for services otherwise payable by DHHS are avoided or recovered from a liable first or third party payer. DHHS is the payer of last resort in the event any one or more other third party payers are responsible for covered services provided to consumers served through the LME. The Contractor's claims system shall include appropriate edits for coordination of benefits and third party liability.

The Contractor may retain any first (patient fees) or third party revenue obtained for consumers served through the LME if all of the following conditions exist:

- (1) Total collections received do not exceed the total amount of the Contractor's financial liability for all persons served.
- (2) State or federal law does not prohibit such recovery.

The Contractor shall obtain, or cause to be obtained, all relevant payer information from each consumer to be served, his or her guardian and/or family. This information should be collected at the consumer's first encounter with the LME or its QPN, but no later than the submission of the first claim for service. The Contractor shall provide available information to each provider involved with the consumer and require the provider to collect the remaining information, if applicable.

5.0 Provider Relations and Support

5.1 Qualified Provider Network Development Plan

The Contractor shall have a Qualified Provider Network (QPN) Development Plan that analyzes the catchment's area population, service gaps, and the adequacy of provider capacity.

In evaluating capacity and determining the size of the network, the Contractor shall include consumer/stakeholder input annually and shall at minimum consider:

- (1) Prevalence and service utilization rates
- (2) The geographic distribution of providers to ensure consumers have access to core services within 30 minutes travel time or no more than 30 miles proximity of their home
- (3) The diversity of the population served
- (4) The emergence of new treatment technologies that require specialist providers
- (5) A commitment to consumer owned and operated businesses
- (6) Assurance that, except for service with very limited usage, consumers have a choice of at least two providers for every core service.

The Contractor shall maintain a current QPN list and service array distribution. The plan shall be reviewed and updated on an annual basis.

5.2 Freedom of Choice

The Contractor shall ensure that at least two providers are available for each type of service. Exceptions for a Freedom of Choice State per Medicaid regulations at 42CFR _____ are made in the following circumstances:

- (1) Recruiting an additional provider would entail significant overhead/fixed costs with insufficient demand to support additional costs;
- (2) the service is so specialized that only one option exists in the service area; and,
- (3) it is important to contract with a sole provider in order to maintain a single entry point for services, reduce confusion and/or streamline access.

5.3 Subcontracting

The Contractor shall assure that all activities carried out by subcontracted providers conform to the provisions of this Contract and comply with the applicable provisions of federal and State laws, regulations and policies.

All subcontracts shall be in writing. The Contractor shall maintain a fully executed original of all subcontracts that shall be accessible to the Department within two

working days of request. The Contractor may not include covenant-not-to-compete requirements in its subcontracted provider agreements. The Contractor may not contract with any individual or entity that has been debarred, suspended or otherwise lawfully prohibited from participation in any public procurement activity.

5.4 Enhanced Benefit Provider Subcontracts

LME contracts with providers of Enhanced Benefits shall contain, at minimum, the following:

- (1) Full disclosure of the amount of compensation to be paid to the provider and the method by which it will be computed.
- (2) Identification of the name and address of the provider.
- (3) A statement stipulating that the contract is entered into solely between the Contractor and the provider and that the State is not a party to the agreement.
- (4) A provision stating the provider is subject to Medicaid audit and program integrity requirements and activities.
- (5) Identification of the population to be served by the provider and the specific services the Contractor will purchase from the provider.
- (6) The amount, duration and scope of covered services to be provided and for which compensation shall be paid.
- (7) The term of the subcontract, including beginning and ending dates, methods of extension, termination and renegotiations.
- (8) The specific duties of the provider regarding coordination of benefits and determination of third party liability.
- (9) A statement that waives the right of the provider to payment if a service is provided without authorization or if the mode of delivery is not within the boundaries of service definitions and best practices and protocols attached to the subcontract.
- (10) A provision that the provider may retain first and third party revenue collected for services authorized by the Contractor up to the extent that such revenue does not exceed the total cost of services for the consumers for whom services have been authorized by the Contractor.
- (11) A description of the provider's consumer enrollment, medical records and accounting and claims processing systems;
- (12) Specification that the provider shall comply with quality management programs and the utilization control and review procedures specified in 42 CFR, Parts 441 and 456, as implemented by the DHHS.
- (13) A provision stating that a merger, reorganization or change in ownership or control shall require a contract amendment. In addition, for Enhanced Benefit providers directly enrolled with the Medicaid program, a provision stating that changes of this type must also be reported to the Division of Medicaid Assistance.
- (14) A provision that the provider shall be fully responsible for all tax obligations, Worker's Compensation insurance, and all other applicable

- insurance coverage obligations, for itself and its employees, and that the Contractor shall have no responsibility or liability for any such taxes or insurance coverage.
- (15) A provision that the provider shall comply with claims submission requirements as described in this Contract.
- (16) A provision that emergency services do not require prior authorization and that, in utilization review, the test for appropriateness of the request for emergency services shall be whether a prudent layperson, similarly situated, would have requested such services. For purposes of this contract, a "prudent layperson" is defined as a person without medical training who exercises those qualities of attention, knowledge, intelligence and judgment which society requires of its eligible persons for the protection of their own interest and the interests of others. The phrase does not apply to a person's ability to reason, but rather the prudence with which he acts under a given set of circumstances.
- (17) A provision that the subcontracted provider may appeal adverse decisions of the Contractor in accordance with the Contractor Provider Appeal Policy;
- (18) Specification that the provider shall assist consumers in understanding their right to file grievances and appeals and follow the LME policies with regard to these processes. The subcontract shall specify that, in the event a consumer served by the subcontracted provider files an appeal or grievance, the subcontracted provider will comply with findings of the Contractor.
- (17) A mandatory reporting policy that includes critical incident reporting.
- (18) A stipulation that no consumer referred for services by the Contractor can be rejected from being served by the provider.
- (19) Provisions outlining access, referral and service authorization procedures.
- (20) Provisions detailing admission, discharge and continuing stay criteria.
- (21) Requirements that the subcontractor adhere to model fidelity requirements of the services provided.
- (22) A provision requiring the provider to coordinate care with other providers within the network and with the consumer's primary healthcare physician.
- (23) Provisions outlining financial stability and audit requirements and requiring the provider to comply with the Contractor's monitoring activities.

5.5 Basic Benefit Provider Subcontracts

All providers of Basic Benefits that are directly enrolled in good standing with the Division of Medical Assistance shall be deemed to be part of the Contractor's QPN. If the Basic Benefit provider wishes to serve only Medicaid eligible consumers and does not wish to receive referrals from the Contractor, no additional agreements are necessary. If a provider directly enrolled with the Division of Medical Assistance and the Contractor agree that the provider will serve non-Medicaid eligible consumers and/or receive direct referrals from the Contractor, the Contractor shall enter into a

simplified Memorandum of Agreement with the provider, outlining billing and payment procedures and procedures for scheduling appointments for consumers.

When the Contractor enrolls Basic Benefit providers into its QPN that are not directly enrolled with the Division of Medical Assistance, the LME shall perform a licensure and credentialing verification prior to referring consumers for services. The Contractor shall enter into a Memorandum of Agreement with these providers that outlines billing and payment procedures and procedures for scheduling appointments for consumers.

5.6 QPN Membership

All providers, whether they are organizations or independent practitioners, may apply for QPN Membership. The Contractor shall specify requirements for certifying organizations and practitioners based upon National Accreditation and State licensing and credentialing practices and regulations.

5.7 Conflict of Interest

The Contractor shall ensure that the QPN is structured to prevent conflicts of interest. Neither the Contractor nor any provider should be able to gain economic advantage by making referrals to or care coordination decisions which benefit related parties.

5.8 QPN Management

The Contractor shall have policies and procedures to manage the QPN. Minimally these procedures shall include:

- (1) Methods for regular communication with providers
- (2) A clear mechanism for dispute resolution
- (3) Procedures for negotiating and managing contracts
- (4) Policies and procedures for provider enrollment, certification, and monitoring.
- (5) Policies and procedures to ensure compliance by its QPN with DHHS specified reporting requirements for communicable disease, other health indicators and safety.

5.9 Training and Support

The Contractor shall ensure that training and technical assistance needs are addressed in the catchment area.

The Contractor shall provide, at a minimum, for the following training topics to be addressed. These training topics may be addressed by qualified trainers or by publication in the Contractor's provider manual.

- (1) Information on the Contractor, the provider system and other State agencies which will assist in the implementation and coordination of care.
- (2) The Contractor's access, screening and referral procedures, including information on target populations.
- (3) MH/DD/SA medical record documentation requirements.
- (4) Coordination of care requirements;
- (5) Consumer confidentiality and HIPAA privacy protections.
- (6) State defined best practices, including the statewide service definitions, utilization management guidelines and requirements, and other clinical documents attached to this contract.
- (7) Definition and purpose of Person-centered planning.
- (8) How crisis plans should be developed and their role in risk reduction for consumers.
- (9) Early, Periodic, Screening, Diagnosis and Treatment (EPSDT) requirements.
- (10) Consumer's rights and responsibilities, including access issues and information regarding consumer appeal and grievance procedures.
- (11) Fraud and abuse requirements and protocols.
- (15) Requirements for ethical behavior such as providing services in a manner that promotes dignity, respect and choice and addresses the prohibition against receiving gratuities from a consumer or offering consumers incentives to influence their choice of provider.

In addition to the topics outlined above, the following topics shall be provided to Therapeutic Foster Care Home parents who serve children and other residential service providers:

- (1) Prevention of violent behaviors;
- (2) Behavior management skills, including skills needed for crisis situations;
- (3) Education on symptoms of specific age populations diagnosed with MH/DD/SA problems;
- (4) Medication administration and the effects of medication on children and adolescents:
- (5) Resources for obtaining assistance and developing home and community supports:
- (6) Documenting progress toward service plan goals and objectives;
- (7) Community living skills training.

Therapeutic Foster Care Home providers shall have completed 20-30 hours of training prior to service delivery and have at least 10 hours of training annually in the topics listed above.

The Contractor shall have a policy and procedure that identifies the need for additional training of providers. Systematic processes such as utilization management review results, complaints and problem resolution data, and grievance

and appeal data may be used to identify providers who require additional training or technical assistance.

The Contractor shall provide training and technical assistance to its QPN and general community as new initiatives and best practices are issued by DHHS.

5.10 Provider Manual

The Contractor shall develop and distribute a provider manual to all service providers in the QPN. The manual shall contain information consistent with state standards, as follows:

- (1) LME Overview: The Contractor shall give the provider a general overview of the mission, vision and guiding principles of its' organization, a diagram and description of the organizational structure, and a clear description of each LME administrative function including: Governance, Business Management and Accounting, Consumer Affairs and Customer Services, Provider Relations and Support, Quality Improvement and Outcomes Evaluation, Service Management and Access, Screening, Triage and Referral.
- Procedures: The Contractor shall provide a detailed description of processes and procedures to be followed for the following: first party fee determination, referral sources, consumer choice, target populations, access to services (emergent and urgent access, inpatient & inpatient alternative level of aare, non-emergent and non-urgent access), initial appointment Intake, Routine Appointments, Service Authorization, Psychiatric Service Referrals, Electronic System Requirements of Providers. The Contractor shall include in the Manual any required forms. The Contractor shall also provide the names and phone numbers of LME staff to consult for further assistance in navigating the system.
- (3) Appointment To The Network: The contractor shall include instructions in the following areas for becoming a member of the QPN, along with a copy of the application: General Requirements, Application Process, Verification of Credentials and Changes in Credentialed Status, Interviews, Applicant Right to Review Decision, Site Reviews and Certification, Additional Privileges/Service Areas, Appointment Process and Conditions and Duration of Appointment, Notification, Voluntary Reduction of Privileges/Service Areas, Reduction in Credentialed Status/Suspension Due to Adverse Findings, Credentialing Appeals and Dispute Resolution and Re-Credentialing and Re-Appointment.
- (4) Service Descriptions, Qualification Requirements, And Eligibility: The Contractor shall specify the Definitions/Requirements and Eligibility Criteria for the Service Array for Persons with Mental Illness, Children with Severe Emotional Disturbances, Persons with Developmental Disabilities, and Persons with Substance Abuse Disorders utilizing documents approved in this contract.

- (5) Training: The Contractor shall provide an overview of the QPN Training Requirements, Training by Service Type, and Training Descriptions.
- (6) Authorization Process: The Contractor shall provide a Service Authorization Overview, provide directions for the Service Authorization Process, provide copies of forms or computer screens to be used, and Service Authorization Grids.
- (7) Claims Payment: The Contractor shall describe the rules and process for Submission and Payment of Claims, procedures for Community Inpatient Providers (Hospitals), any special procedures for Providers Connected Electronically (or not), Authorization for Secondary Coverage, and how Payments will be made and shall include Service Activity Codes and Rates.
- (8) Standards And Regulatory Compliance: The Contractor's Provider manual shall include a detailed set of standards providers are required to meet in an organized format that includes: Administration and Leadership, Finance and Business, Client Rights, Management Information Systems, Professional Competency and Credentialing, Quality Improvement and Performance Monitoring, Corporate Compliance, General Medical Record Requirements, Assessment, Treatment Referrals, Individualized, Person-Centered Treatment, Crisis Intervention, Professional Treatment Monitoring, Discharge Planning, Service Delivery, and Environment of Care Performance Improvement, and Provider Profiling. The Contractor shall list source documents that support the standards required of the QPN
- (9) Medical Records: The Contractor shall specify how Medical Records will be coordinated in the Network to promote effective care.
- (10) Disputes and Appeals Process: The Contractor shall describe Filing a Recipient Rights Complaint, the Formal Complaint Process, the process for Treatment Disputes/Grievances, Second Opinions and Appeals, the processes for Denial of Initial Access, Denial of Hospitalization and the notice process the Contractor shall follow whenever there is a Suspension, Reduction or Termination of Existing Services. The Adequate Notice Process shall include the Adequate Notice Definition, Denial of Initial Access Second Opinion Upheld, Denial of Hospitalization Second Opinion Upheld, and Denial of Additional Services.
- (11) Adverse Action: The Contractor shall describe the Advance Notice of Adverse Action Process
- (12) Ability to Pay/Fee Determination Appeal: The Contractor shall describe the Ability to Pay/Fee Determination Appeal process.
- (13) Provider Appeals: The Contractor shall provide a description of contractual appeals process for subcontracted providers.
- (14) Medical Guidelines and Best Practice: The Contractor shall specify policy and procedure regarding medical practice minimally including Prescription of Medication, Poly-pharmacy, Responsible Physician, Drug Management & Indigent Medications, Policy on out -of-network prescription of medication and the requirements for Care Coordination.

- (15) Treatment Protocols: The Contractor shall provide the QPN with State adopted Treatment Protocols for:
 - (a) Mental Health Disorders: A Conceptual Framework of the Treatment Culture, Chapter I: Values, Chapter II: Treatment Protocols including Psychotic Disorders, Affective Disorders, Attention Deficit/Hyperactivity Disorder, Conduct Disorder and Oppositional Defiant Disorder, Personality Disorders, and Anxiety Disorders, Chapter III: Critical Pathways Chapter IV: Level of Care Guidelines, Chapter V: Guides for the Consumer, and References
 - (b) Developmental Disabilities: Chapter I: the Supports and Treatment Culture, Principles, Values and Promoting Self-Direction; Chapter II: Supports & Treatment Protocols for Pervasive Developmental Disorders and Mental Retardation; Chapter III: Critical Pathways including Eligibility and Diagnostic Assessment and Supports and Treatment; Chapter IV: Level of Care Guidelines including Evaluation of Parameters for Assessment of Service Need and the Level of Care Assessment; Chapter V: Guidelines for Consumers and Their Families and References.
 - (c) Substance Abuse Disorders: as defined in the National ASAM protocols.
- (16) Fidelity Models: The Contractor shall provide the QPN with Evidence Based Practice Models consistent with State Service Definitions including ACTT, PSR, MST, and others as included in the enhanced benefit package.
- (17) Utilization Management Tools: The Contractor shall provide examples of UM Tools to be used for reviews.
- (18) Disaster Preparedness, Response, and Recovery: The Contractor shall define QPN responsibilities during the four phases of a disaster: Planning and Preparedness, Alert and Mobilization, responsibilities during the Response Phase and responsibilities during Recovery Phase.
- (19) Glossary of Terms: The Contractor shall define key terminology pertinent to the QPN.

The Contractor shall modify the provider manual within 30 days when notified by DHHS of required revisions.

6.0 Access, Screening, Triage and Referral

6.1 Policy and Procedure

The Contractor shall have a policy and procedure that describes the Access, Screening and Triage function. The procedure shall include the following;

- (1) Triage for level of care: Emergent, Urgent or Routine.
- (2) Eligibility determination for service and benefit package.
- (3) Pre-authorization for timely emergency services and pre-authorization

- protocols for urgent and routine services to assist the consumer in getting to the point of assessment and service planning within 7 days.
- (4) The process for notifying the provider of authorization and enrollment.
- (5) Appropriate referral for persons not eligible for Contractor services.
- (6) Adequately-trained staff that are supervised by a qualified clinician.
- (7) Collection of first and third party payment information.
- (8) Care coordination for consumers until an "active linkage" is established.
- (9) Implementation of documented consumer crisis plans.
- (10) Collaboration with local agencies, particularly law enforcement and the County Department of Social Services.
- (11) Provision of information to the consumer to make an informed choice of provider.
- (12) Provision for providing consumers with Member Handbooks, payment requirements, notice of privacy and Consumer Rights information; and means for consumer appeals of decisions.

6.2 Single Entry for State Operated Services

A single entry mechanism shall be in place for admission to and discharge from state operated services.

6.3 Referrals

The Contractor shall accept and act upon referrals and requests for covered services from consumers or their guardians or family members, acute care providers, primary physicians, hospitals, courts, tribal governments, Indian Health Services, schools or other State or community agencies.

6.4 Access Line

The Contractor shall provide or subcontract for an Access line that is staffed 24/7 with live, trained personnel, TTY capable for persons who have a hearing impairment, and foreign language interpretation at no cost to the individuals requiring assistance. Accommodations shall also be made for cultural and demographic differences, visual impairments, augmentive communication, and mobility or other handicap accessibility to the Contractor and the QPN. The Access line shall be toll-free for all residents of the Contractor's catchment area.

6.5 Uniform Screening

The Contractor shall utilize the uniform screening protocols attached to this contract in Attachment III-4 to ensure that consumers who need or request covered services receive timely and appropriate service, based on the need identified in the screening. The Contractor shall assess and serve promptly in a friendly and caring manner all individuals presenting for access and triage.

The Contractor shall perform a risk assessment of sufficient detail to determine need for emergent, urgent or routine service:

- (1) Emergent is defined as "an acute disturbance in thought, mood or social relationship that requires an immediate intervention as defined by the consumer, family or the community". This includes persons who are intoxicated or in withdrawal and unable to access services without immediate assistance.
- Urgent is defined as evolving more slowly than an emergency where catastrophic outcome is not imminent. In urgent situations, care can be provided in order to avoid the potential development of an emergency. This includes persons who are intoxicated or in withdrawal seeking treatment and for whom rapid access to care will leverage motivation for care.
- (3) Routine is defined as a request for help wherein the individual's need is not acute nor is crisis imminent. This includes individuals that may be referred by the court for DWI.

The Contractor shall document the following:

- Level of acuity;
- (2) Presenting problem;
- (3) Diagnosis;
- (4) Functional level;
- (5) Availability of family or environmental support;
- (6) Involvement with other agencies.

6.6 Care Coordination

The Contractor shall assure coordination and provision of interim services when a consumer requires services from another Contractor or QPN.

6.7 Public Education, Outreach and Promoting Self-Help

The Contractor shall publicize the phone number and location of designated access points and shall provide Information and education to the general public about MH/DD/SA disorders and how to access services.

Outreach shall occur for vulnerable and at-risk populations to consumers of the availability of MH/DD/SA services in accordance with DHHS policies on outreach. The Contractor shall utilize penetration rates and other quality management measures to assess the effectiveness of these outreach efforts.

The Contractor shall assure that support and self-help is available to people before, during and after enrollment in the MH/DD/SA system.

6.8 Choice

An eligible person's choice of provider within the Contractor's QPN shall be honored by the Contractor, subject to medical necessity and utilization management criteria and the Contractor's provider enrollment policies and procedures.

7.0 Service Management

7.1 Target Population

The Contractor, either directly or through subcontractors is responsible for the provision of all medically necessary covered MH/DD/SA services to all Medicaid eligible individuals in the catchment area. The Contractor, either directly or through subcontractors, is responsible for the provision of medically necessary covered MH/DD/SA services to non-Medicaid eligible consumers located in the service area defined as target populations, up to the level of available funding. Nothing in this Contract shall be construed or interpreted as creating an entitlement to services funded through State or State-allocated federal funds. All services shall be provided in accordance with applicable federal, State and local laws, rules, regulations and policies, including services described in this Contract and those incorporated by reference throughout this Contract. The Contractor shall prioritize the delivery of services to non-Medicaid eligible consumers based on the availability of funding consistent with the State Plan

7.2 Medical Necessity and Practice Expectations

The Contractor shall use the medical necessity criteria specified by DHHS. Medical necessity is commonly defined as a determination that a specific service is medically (clinically) appropriate, necessary to meet the person's mental health/developmental disability/substance abuse needs, consistent with the person's diagnosis, symptoms and functional impairments, is the most cost-effective option in the least restrictive environment, and is consistent with clinical standards of care.

The Contractor shall provide service at medically necessary levels in the appropriate amount, duration and scope as defined in this contract.

The Contractor shall utilize the Utilization Management and Level of Care Guidelines for Mental Health and Substance Abuse Services, and Services for People with a Developmental Disability attached to this contract.

The Contractor shall implement the Evidence-Based Best Practices defined in the Service Definitions and Treatment Protocols.

7.3. Continuum of Service

The Contractor shall ensure that a continuum of services consistent with the State Plan and Service Definitions attached to this contract is available to meet the needs of consumers. All service definitions, unless explicitly stated otherwise, refer to developmental disabilities, substance abuse/dependence and mental health services and populations. The DHHS, in the benefit package description, provides a listing of covered services and procedure codes under this Contract.

7.4 Enrollment

The Contractor shall ensure that all consumers who receive covered services are enrolled in the DHHS Information System in a timely manner. The Contractor shall implement platforms to ensure the accuracy, completeness and timeliness of all required data submissions.

Consumers shall be immediately enrolled when the provider delivers a covered service approved by the LME. In these situations, the effective date of enrollment shall be no later than the date on which the first MH/DD/SA service was delivered, including crisis services.

The Contractor shall ensure that complete, timely and accurate enrollment and assessment data is entered into DHHS Information Systems in accordance with DHHS data processing requirements and policies. The Contractor may be sanctioned for untimely, missing, incomplete, inconsistent or inaccurate data, in accordance with this contract.

The Contractor is responsible for verification of eligibility for Medicaid and other entitlement benefits and for notifying the DHHS of changes in status of eligible persons as required by DHHS policies and procedures. Loss of entitlement benefits eligibility is effective immediately upon death of the person. Services provided to a Medicaid eligible consumer incarcerated in a city, county, State or Federal correctional facility for more than 72 hours are not billable to the Medicaid program.

7.5 Eligibility

The Contractor is responsible for determining potential eligibility for entitlements and for referring consumers to the appropriate resource.

7.6 Disenrollment

The Contractor shall ensure outreach activities that include making repeated documented attempts, including follow-up telephone calls and home visits, to reengage consumers who refuse services or who fail to appear for appointments. The Contractor shall ensure that evaluation and treatment procedures are initiated for consumers who may be dangerous to themselves or to others.

If an consumer still in need of covered services is disenrolled as a result of a change of residence, the Contractor shall assist the consumer in transition to another Contractor or provider and shall ensure that an appropriate medical professional gradually decreases the medications in a safe manner, or continues to prescribe psychotropic medications until an alternate provider has assumed responsibility for care of the consumer.

When a person no longer requires covered services, or when repeated attempts to re-engage the person are unsuccessful, the person shall be disenrolled. The Contractor shall ensure that consumers are disenrolled within 90 days after the last service authorized or last contact.

Required disenrollment and final assessment data shall be submitted to the DHHS Information system within fourteen (14) days of the disenrollment date.

7.7 Notice of Service Denial, Suspension, Reduction or Termination

The Contractor shall address advance and adequate notice in its Utilization Management (UM) Plan and comply with the following whenever covered services are denied, reduced, suspended or terminated:

- (1) The Contractor shall provide notices in accordance with DHHS policy and procedure using the forms prescribed by DHHS for consumers.
- (2) The Contractor shall follow the treatment protocols attached to this Contract when denying, reducing, suspending or terminating covered services.
- (3) The notice prescribed by DHHS shall be used to provide consumers prior written notice of a reduction, suspension or termination of a service.
- (4) When a service is subject to prior authorization, the Contractor shall comply with all notice, appeal and continuation of benefits requirements specified by State and federal law and regulations.

7.8 Person Centered Plan

The Contractor shall authorize the purchase of services based upon a Person Centered Plan (PCP). The PCP guidelines are attached to this Contract in Attachment III-7.

The Contractor shall develop natural and community supports to assure that persons with disabilities are integrated fully in the community in the least restrictive setting. The Contractor shall also assure the development of community and natural resources to support the non-target population.

The Contractor shall insure consumer and family involvement:

- (1) Enrolled persons and their families shall be active participants in planning for and evaluating the services provided to them.
- (2) Service strategies routinely include instruction and support in self-management of MH/DD/SA disorders, relapse-prevention and recovery.
- (3) Prevention, early intervention, crisis response, treatment, rehabilitation, recovery and community integration services shall be designed to meet the culturally diverse needs of local communities.
- (4) Resources are flexibly aligned with identified community need. Changes to the MH/DD/SA service system shall be planned and evaluated with participation by consumers, families, other service agencies and key community leaders.
- (5) Access to housing, employment, medical and dental care and other community services needed by enrolled persons shall be maximized through strategic partnerships that support growth and recovery.

7.9 Effective Innovation

The Contractor shall address effective innovation:

- (1) Services shall be delivered in accordance with evidence-based best practices and empirical evaluation of provider results.
- (2) The Contractor and its QPN shall integrate substance abuse and mental health evaluation and treatment as the best practice standard recognizing that developmental disabilities, substance abuse and mental health disorders are inextricably intertwined.
- (3) Research shall be conducted and pilot programs with promise are replicated and researched to improve the service outcomes for special population groups.
- (4) Promising or Probably Efficacious Treatment models shall be replicated and research produced to contribute to the EBP literature.

7.10 Cultural Competence and Proficiency

The Contractor shall demonstrate, both directly and through its QPN, an ongoing commitment to linguistic and cultural competence that ensures access and meaningful participation for all people in the service area. Such commitment includes acceptance and respect for the cultural values, beliefs and practices of the community, as well as the ability to apply an understanding of the relationships of language and culture to the diagnosis and delivery of supports and services.

All printed information and materials for enrolled persons shall be translated when a language is spoken by 3,000 individuals or three percent (3%) population of the catchment area, whichever is less. Public materials shall be written at a 6th grade or lower level of proficiency.

Accommodations are required for deaf and hard of hearing individuals and those without sight. To effectively demonstrate such commitment, it is expected that the Contractor shall have the following components in place:

- (1) A method of community assessment;
- (2) A policy and procedure that reflects value and practice expectations;
- (3) A method of service assessment and monitoring for application of cultural competency best practice;
- (4) Ongoing training of Contractor and QPN staff;
- (5) The provision of supports and services within the cultural context of the recipient.
- (6) Evidence that Providers are recruited and evaluated based on competence in linguistically and culturally appropriate assessment, location of service sites, outreach strategies and outcomes;
- (7) Contractor management that reflects cultural diversity in values and policies;
- (8) A mechanism of continuous improvement through periodic cultural self-assessment and program modification.

7.11 Utilization Management Plan

The Contractor shall have a Utilization Management Plan (UM) that has the following essential elements:

- (1) The UM statement of principles and philosophy that reflect the values inherent in the State Plan, the Child Plan, and the desire of the organization to be welcoming and compassionate.
- (2) A procedure that does not delay services because of an authorization process;
- (3) A staffing pattern of experienced, culturally competent qualified UM professionals across age (adult, child and adolescent) and disability groups.
- (4) A process for authorization that includes:
 - (a) An effective date and an end date for the service authorized
 - (b) The scope of service (definition and route of delivery) authorized
 - (c) The amount frequency and duration of service authorized
 - (d) A process at triage for immediate authorization of initial services designed to facilitate a thorough evaluation for emergent and urgent care and necessary treatment; or for a routine assessment by a provider to enable the PCP process to occur.
 - (e) A procedure for choice of provider within the Contractor network.
 - (f) A procedure for timely (less than 3 days) response to routine authorization requests that results in an approved, pended or rejected notice pursuant to a PCP that has clearly stated outcomes and specifies community and natural supports resulting in a net need for public services.

- (g) A procedure for care management that includes "specialist review" or "second opinion" for issues related to differences in independent clinical judgment and seeking specialist services needed but not available in the network.
- (h) A procedure for authorizing new services pursuant to an amended PCP.
- (i) A procedure for reauthorization that takes into account review of functional outcomes and increased community and natural supports.
- (j) A procedure for notification to the consumer of the authorization or denial and their rights of appeal.
- (k) Procedures for authorizing service pending the need to gather additional information or pending an appeal of a denial or reduction in service.
- (I) A procedure for notifying the State vendor of authorizations to permit claims payment, if applicable.
- (5) Procedures for continuing stay review and retrospective review conducted on a representative sample of authorizations by service definition, by diagnosis, and by age group.

7.12 Outcomes

The Contractor shall have procedures for measuring functional outcomes and improving provider performance and a procedure for stakeholder assessment of satisfaction with the UM process.

7.13 Inpatient Agreements

The Contractor shall maintain written agreements with all public and private inpatient facilities in the catchment area that delineate the roles and responsibilities of each party.

The contractor shall maintain a specific contractual relationship with State operated facilities that are responsible for serving consumers from their geographic area. The Contractor shall have a policy and procedure that governs the use of State operated services through a single entry system. The procedure shall include the following:

- (1) Medically necessary inpatient care shall be authorized in advance for all admissions in those instances where there is no community inpatient alternative. The Contractor shall review treatment at intervals and determines whether continued services are medically necessary.
- (2) Procedures for implementation of single entry responsibility shall be addressed in the agreements between the Contractor and each admitting hospital/center.
- (3) The Contractor authorization of admission and of continued treatment is the basis on which the Contractor shall authorize reimbursement of services provided in a State operated hospital/center.

- (4) Authorizations for State operated care shall be conveyed in writing or electronically to the hospital/center.
- (5) Disputes between the State operated facility and the Contractor regarding admission, discharge and continued stay of consumers shall be resolved in accordance with the provisions of 10 NCAC28F.0212.

7.14 Crisis Services

The Contractor shall maintain a 24-hour, seven day a week crisis response service and telephone number for consumers that is publicized in the community(s) served by the Contractor. Crisis phone response shall include triage, referral and dispatch services and patch capabilities to and from 911 and other crisis providers as applicable. Crisis services do not require prior authorization but shall be delivered in compliance with Contractor policies and procedures. Crisis services shall be designed for crisis prevention, intervention and resolution, not merely triage and transfer, and shall be provided in the least restrictive setting possible, consistent with individual and family need and community safety.

7.15 Health and Safety Collaboration

The Contractor shall initiate collaborative efforts with fire, police, EMS, hospital emergency departments and other providers of health and safety services to:

- (1) Coordinate dispatch, assessment, transportation and crisis interventions with local community crisis providers (police, fire, ambulance, county health departments, hospitals);
- (2) Develop protocols for and education on the appropriate use of Contractor crisis services as opposed to hospital emergency departments; and
- (3) Meet regularly with representatives of fire, police, EMS and hospital emergency departments to coordinate services and to assess and improve Contractor crisis response services.

7.16 Medical Emergencies

The Contractor shall have a protocol for access to medical services for medical emergencies and for determination of medical stability prior to admission to any residential facility without on site medical services.

7.17 Involuntary Evaluation

The Contractor shall have a protocol for evaluation for involuntary commitment.

7.18 Prior Authorization

The Contractor's crisis response function shall render prior authorization decisions for inpatient hospital admissions and sub-acute facilities within one hour of request.

The Contractor shall monitor its performance against this standard and take appropriate action if it is determined that the standard is not being met.

7.19 Second Opinion

The Contractor shall ensure 24-hour access to a psychiatrist for a second opinion on any denial of inpatient admission.

7.20 Walk-in Capacity and Staffing

The Contractor shall ensure sufficient availability of walk-in and/or drop-off crisis and detoxification capacity to meet the needs of consumers. Walk-in and drop-off capability shall be available 24 hours a day, seven days a week and include nursing or other medical staff capable of recording and evaluating vital signs and assessing emergent medical needs. Professional staff shall be available for preparation of petitions for involuntary commitment evaluations. Walk-in and drop-off services shall be available, at a minimum within 30 minutes travel time or within 30 miles of any inhabited area in the catchment area covered by the Contractor.

7.21 Mobile Crisis Services

The Contractor shall have mobile crisis capacity to perform face-to-face crisis response and evaluations prior to any inpatient admission.

7.22 Emergency Room Settings

The Contractor is responsible for medically necessary psychiatric and/or psychological consultations provided to consumers in emergency room settings.

7.23 Transportation

The Contractor shall assist consumers in coordinating and addressing transportation needs. Unless located in a general medical facility, the Contractor shall provide medically necessary non-emergency transportation to a general medical facility for persons identified as requiring medical clearance prior to further MH/DD/SA evaluation and treatment. The Contractor is not responsible for providing necessary emergency medical transportation.

7.24 Assessment

The Contractor shall ensure that consumers do not have to unnecessarily repeat intake and assessment information. The initial Assessment shall follow a protocol adopted by the Contractor for its QPN that shall include the following considerations:

(1) All initial assessments shall be performed by staff that are trained and credentialed to perform assessments of MH/DD/SA disorders.

- (2) The initial assessment shall include recommendations for services, including service coordination.
- (3) The Contractor shall ensure the review of the initial assessment and treatment recommendations by a licensed medical professional with prescribing privileges for consumers identified as needing psychotropic medications for a MH/DD/SA condition.

7.25 Active Treatment

The Contractor shall implement policies, procedures, performance standards and a monitoring process to ensure medically-necessary active treatment for all consumers and continuity of care between providers, settings and treatment episode, including:

- (1) Initiation of medically necessary services within 7 days of referral;
- (2) Assignment to a provider deemed competent and credentialed by the Contractor to serve as a fixed point of accountability;
- The Assigned Provider shall be responsible for clinical oversight, (3) assessment, service planning (PCP), timely submission of requests for authorization or reauthorization of services to be provided, delivery of authorized medically necessary services, transmittal of assessment, treatment and discharge recommendations to the eligible person's primary care physician, ongoing assessment of MH/DD/SA needs, revision of the Person Centered Plan and service delivery based on progress towards MH/DD/SA goals; provision of authorized services and/or requests for authorization to other needed treatment, rehabilitative, supportive, ancillary and emergency services; referral to community resources; monitoring of MH/DD/SA condition and provision of intervention as needed; ongoing collaboration with guardians, family members, significant others, other community service agencies, other involved service providers, and State agencies or other individuals identified by the eligible person, as needed for the delivery and coordination of services: maintenance of continuity of care between inpatient and outpatient settings; development and implementation of transition, discharge and aftercare plans prior to discontinuation of MH/DD/SA services; transfers to out of area, out of state, or to another LME, as applicable and; to support and complement the work of Child and Family Teams.

7.26 Timeliness

The Contractor shall require all providers to initiate covered services in accordance with the following standards: Emergency – within one hour; Urgent care – within forty-eight (48) hours; Routine care – within seven (7) days

7.27 Service Record

The Contractor shall establish and maintain a comprehensive consumer service record system consistent with State and federal rules and regulations and policies and procedures. The Contractor shall maintain in a legible manner, via hard copy or electronic storage/imaging, recipient service records necessary to fully disclose and document the quantity, quality, appropriateness, and timeliness of services provided and to permit effective professional review and audit by facilitating prompt and systematic retrieval of information. The records shall be retained for the duration and in the format prescribed by the Division of Mental Health, Developmental Disabilities and Substance Abuse Services Service Records Manual.

7.28 Critical incidents

The Contractor shall ensure compliance by its QPN with DHHS specified reporting requirements for communicable disease, other health indicators and safety.

The Contractor shall establish benchmarks and accumulate information about the rate at which clinically undesirable and avoidable events occur. The Contractor shall monitor the data for trends that would signal episodes of quality problems in its system of care.

Critical incidents include but are not limited to deaths, critical incidents, unusual incidents, rights violations, safety violations, code of professional conduct violations, violations of licensure, and other incidents or outcomes that reduce quality of life and impact functional outcomes.

7.29 Community Collaboration

The Contractor shall comply, and require its QPN to comply, with all collaboration requirements established by this contract. Whenever, by the terms of an intergovernmental agreement, the duties or obligations of the DHHS may be met either by the DHHS acting directly or through the Contractor said duty or obligation shall be performed by the Contractor in a manner consistent with the terms and conditions of the intergovernmental agreement and the Contract. The terms of the Contract shall govern and the Contractor shall immediately notify DHHS of any conflict.

The Contractor shall work closely with local public and private community-based organizations and providers to address prevalent human conditions and issues that relate to a shared customer base and make a wider range of essential supports and services available to Contractor recipients. Such agencies and organizations include local health departments, local health provider systems, local DSS offices, community and migrant health centers, school systems, and Rehabilitation Services.

The Contractor shall also collaborate with other agencies providing services and

supports needed by enrolled persons and their families, including but not limited to: general medical care; probation, parole, and court services; services to the homeless; faith based groups; shelters; bereavement groups; leisure activity; the elderly, emergency medical services, child welfare, religious institutions, housing and urban development, safety services including disaster planning, domestic violence services, and fire, police and sheriff's departments.

The Contractor is encouraged to participate in multi-purpose human services collaborative bodies, and other similar community groups.

The Contractor shall have a written collaboration agreement with each of the pertinent agencies noted above describing the coordination arrangements agreed to and how disputes between the agencies will be resolved. To ensure that the services provided by these agencies are available statewide, an individual Contractor shall not require an exclusive contract as a condition of participation with the Contractor.

7.30 Coordination of Care

The Contractor shall ensure that consultation services are made available including describing how to access consultation and methods to initiate a referral for ongoing MH/DD/SA services. The Contractor shall have documented policies and procedures to assure that coordination regarding consumers is occurring between the Contractor and/or its provider network, and the following key systems:

A. Primary Care Physicians:

The Contractor shall minimally address all recipients of Contractor services for whom services or supports are provided for extended periods of time. The Contractor shall ensure timely sharing of information with the Primary Physician (PP) for children and youth who are enrolled in Carolina Access. Coordination efforts shall occur for adults as well. At a minimum, the Primary Physician should be notified in the following circumstances:

- (1) Initial assessment and treatment recommendations; changes in Psychotropic medications and adjustments to them; emergency/crisis admissions or events; discharge from an inpatient setting; significant changes in condition, changes in ongoing care, changes in medications and disenrollment from the Contractor or any other events requiring medical consultation.
- (2) Notification shall include:
 - (a) Notification of receipt of a referral;
 - (b) The name, address, telephone, and fax number of the Responsible Clinician; and
 - (c) Sufficient information to allow for the coordination of MH/DD/SA services with the general medical care provided by the PP, consistent with DHHS requirements.

The Contractor shall monitor compliance with these notification requirements through periodic case file review, trends in grievance and appeal, problem resolution data and other quality management activities.

In order to ensure effective coordination of care, proper consent and authorization to release information to PPs should be obtained pursuant to HIPAA privacy regulations. The Contractor shall inform all enrolled persons of the nature and extent of the treatment information that will be shared with the primary physician to coordinate care.

Eligible persons with diagnoses of mild depression, anxiety or attention deficit hyperactivity disorder being treated by the Contractor QPN physician once stable may be referred back to the PP for ongoing care after consultation with the enrolled person's PP. The Contractor shall systematically review the appropriateness of decisions to refer eligible persons to the PP for ongoing care under the guidelines for use of psychotropic medication.

The Contractor shall ensure physician-to-physician interaction when necessary between the prescribing physician, nurse practitioner or physician assistant and the primary care provider in cases involving medical conditions and/or medication interactions that pose a risk of harm to the enrolled person.

The Contractor through the QPN shall provide psychiatric consultation services for primary care providers who wish to prescribe psychotropic medications within their scope of practice. Consultation services shall include direct access to psychiatrists (or other MH/DD/SA providers, if applicable); recommendations to the primary care provider by the psychiatrist regarding the primary care providers' management of the eligible person's MH/DD/SA condition and services that should be performed through the Contractor in addition to psychotropic medication management by the primary care provider or that ongoing management should be performed through the provider, based on the severity or complexity of the consumer's MH/DD/SA condition; and provision of information to physicians about how to access these services.

Contractor shall cooperate with DHHS in implementing and complying with any additional policies and procedures established for monitoring and improving communication between acute care and the Contractor or its QPN.

B. Schools:

Prevention, screening and early identification programs shall be delivered in or near school settings, and shall be provided in collaboration with local educational authorities.

Information and recommendations contained in the individual education plan (IEP) are considered in the development of the service plan for the enrolled person; the assigned clinician or designee participates with the school in development of the IEP to ensure that the most appropriate, least restrictive MH/DD/SA services are recommended in the IEP.

Transitional planning with the school occurs prior to and after discharge of an enrolled person from any out of home placement, including a residential treatment center to a local school authority. Transitional planning shall occur for persons aging out of the educational system and being referred for MH/DD/SA services.

C. Child Welfare:

Information and recommendations in the child welfare case plan are considered in the development of the service plan for the enrolled child, and the Service Coordinator is invited to participate in the development of the service plan and all subsequent planning meetings.

Providers coordinate, communicate and expedite MH/DD/SA services to assist local DSS personnel in reducing the amount of time children spend in the custody of the state, improving stability of placements and in finding permanent placement for children, according to requirements addressing pertinent legal mandates.

D. Criminal Justice:

The Contractor shall ensure that: Individuals with mental health, developmental disability and substance abuse service needs are diverted from correctional settings when possible and that eligible individuals are provided treatment suited to their condition.

Persons involved in the adult criminal justice system (including individuals under probation, parole or post-release supervision, with pending charges, etc.) shall be referred to local Treatment Accountability for Safer Communities (TASC) services for screening, assessment, person-centered planning. Coordination with TASC shall occur for the authorization and provision of MH/DD/SA services in accordance with target population guidelines.

Children with mental health, developmental disabilities and substance abuse service needs involved in the juvenile justice system are screened and have access to the full continuum of services and supports. The Contractor shall inform Detention Centers and Youth Development Centers of the availability of services and supports and of procedures to refer eligible children for services. Eligible children in Centers are provided assistance in transition planning prior to discharge.

The Contractor shall provide services designed to divert individuals with a MH/DD/SA diagnosis from incarceration prior to booking, when appropriate. The

Contractor shall collect data reflective of jail diversion activities and outcomes. The Contractor shall ensure that jails have access to screening, assessment, and consultation services for individuals who are in jail and may have a serious mental illness or pose a risk of suicide. The Contractor shall participate in discharge planning for eligible persons with a serious mental illness or developmental disability who agree to ongoing treatment.

E. State Operated Services:

The Contractor is responsible for authorizing all state operated services. The Contractor shall develop a transition plan for all clients requiring a lower level of care.

F. Vocational Services:

Vocational Services: The Contractor shall comply with the DHHS Vocational Services MOA with regard to individuals with a serious mental illness.

The Contractor shall: collaborate with the Division of Vocational Rehabilitation (VR) counselors and/or employment specialists in the development and monitoring of employment goals, and shall ensure that all related vocational activities are documented in the primary MH/DD/SA record;

The Contractor shall ensure coordination and consistency for the delivery of vocational services; assist, as requested, in identifying space and other resources for VR counselors and employment specialists working with enrolled persons; provide reports upon request that show the status of individuals who are receiving extended support services including whether or not extended support services are being delivered.

The Contractor shall develop and implement programs to increase the number of enrolled persons who are successfully employed using the combined resources of the Contractor, VR, and DSS job training programs.

G. Housing Resources:

The Contractor is responsible for the development and management of a comprehensive housing program up to the level of available funding. The housing program shall include a range of housing options from independent living to more restrictive settings.

The Contractor shall develop an annual assessment of the housing needs of the target population collaborating with other disability and affordable housing advocates in efforts to assure that a fair share of public resources are targeted to extremely low income persons with disabilities. This effort includes participating in the area's local planning process and representing the needs of consumers in the local Continuum

of Care planning process; creating an inventory of currently available housing resources accessible to consumers, families and service providers; maintaining information on the unmet housing needs of persons served by the Contractor, prioritizing these needs and developing strategies to address them.

The Contractor shall work with local Public Housing Authorities and Section 8 agencies to improve access and increase the supply of these resources.

The Contractor shall develop Low Income Housing Tax Credit plans and support a continuing relationship to assure that units remain available to MH/DD/SA consumers.

The Contractor shall continue to administer current HUD Homeless Assistance grants providing local liaison to the development and operations of residential programs including Oxford Houses, 122C Supervised Living.

The Contractor shall assist consumers and advocate on behalf of consumers under the NC Landlord – Tenant and Fair Housing law and negotiating Reasonable Accommodations.

7.31 Substance Abuse Block Grant Requirements

The Contractor shall develop and implement primary prevention programs in accordance with the DHHS Prevention Guidelines to reduce the risk of MH/DD/SA disorders and to improve overall MH/DD/SA status in targeted families and communities. Services shall be provided based on identified risk factors to communities and neighborhoods with high proportions of at-risk persons. The Contractor shall submit a report describing its prevention system in a format prescribed by DHHS.

The Contractor shall provide services through Substance Abuse Prevention and Treatment Block Grant (SAPTBG) in accordance with the SAPT Performance Partnership Program. The Contractor shall establish programmatic and accounting procedures consistent with the requirements of 45 CFR Part 96, and DHHS policy and guidelines on CMHS and SAPTBG Program and Funds Management.

The Contractor shall establish a policy and procedures for ensuring access to treatment for pregnant women and injection drug users. At a minimum, the process shall include a wait list management process that includes: a unique identifier for each injection drug abuser seeking treatment; and a unique identifier for each pregnant woman/woman with dependent children seeking treatment, including those receiving interim services. The Contractor shall incorporate data and findings of the wait list management process in identifying service gaps and expansion needs in the annual Provider Network Analysis.

The Contractor shall have a plan to meet the federal SYNAR amendment including: a liaison for reducing youth access to tobacco products; at least 8 hours per month of consultation directed to primary prevention youth access, merchant education, and law enforcement; and event documentation and reporting.

7.32 Child Plan

The DHHS has developed Memorandum of Understanding, which envisions the development of a comprehensive, coordinated system of care for children. Parties to this MOU include the DHHS, DJJDP, DPI, DSS, and AOC. Under the MOA, various interagency projects and systems are established. The Contractor is required to participate in MOA activities and adhere to MOA initiatives. The MOA is included in Attachment III-8.

7.33 Disaster Preparedness

The Contractor shall have a disaster plan that is service-area-wide in its focus, addresses disaster preparedness planning, response, and recovery on a county-by-county basis, and adheres to the requirements for the Contractor in the DHHS Disaster Preparedness, Response, and Recovery Plan. An annual update or revision of plans and a comprehensive review of the plan with all staff is required.

The disaster plan shall describe how it will address the probable disaster needs of the local community as well as the consumers of publicly funded MH/DD/SA services within the catchment area of the Contractor.

The Contractor's disaster plan is required to include the following elements, to ensure that the following activities are carried out and to provide for delivery of the following early intervention services during the four disaster phases:

- (1) The Planning and Preparedness Phase: Includes the time period before a disaster. Activities include the development of plans and participation in local, regional, or statewide training exercises. The disaster plan shall include the Contractor and its providers as both survivors and responders. The Plan shall address internal lines of authority and action, incorporate coordinated planning with the Emergency Management authorities in the local counties of Contractor catchment area, and the provision of appropriate training for early intervention staff.
- The Alert and Mobilization Phase: includes the time period immediately preceding a forecasted disaster. Activities include activating the local disaster plans, notifying the local systems to go on Alert, and reassigning staff in preparation for the event. The Contractor shall provide brief orientation and training; assigning staff to stand-by status; deployment of staff to shelters and local Emergency Operations Centers; assigning staff to needs assessment teams; early intervention teams, community relations teams, and taking inventory of supplies and equipment.

- (3) The Response Phase: Focuses on disaster early intervention services from impact until the Recovery. During this six to eight week period, resources from within the MH/DD/SAS system are dedicated to the affected areas until the crisis is resolved or federally supported crisis counselors are hired to take over the longer term services needed by survivors. The two primary goals are: restoring the normal operations of the Contractor and its provider network; stationing staff at congregate sites in the community where survivors are likely to be sheltered (if not previously deployed during the Alert and Mobilization phase) and where survivors will seek assistance (e.g. American Red Cross Disaster Response Centers). Activities include outreach to the public and MH/DD/SAS consumers; early intervention to affected individuals and responders; and identification of people in need of longer-term crisis counseling or MH/DD/SA services.
- (4) Recovery Plans and Activities Phase: The Recovery phase addresses the provision of crisis counseling services to survivors for a nine-month period via the FEMA Regular Services Grant. Full- or part-time temporary staff, usually indigenous workers with trained and experienced clinical supervisors, provides these services. These services are provided in community settings where survivors live, work, go to school, and congregate. Counties that have received a Presidential Disaster Declaration are eligible to be included in a FEMA Regular Services Grant. The Contractor shall respond to the recovery needs of MH/DD/SAS consumers, other community members, and disaster responders either through local resources or through a FEMA Regular Services Grant.

8.0 Customer Services and Consumer Rights

8.1 Policy and Procedure

The Contractor shall have a policy and written procedures that describe this function including:

- Identifying the Customer;
- (2) General Customer Services;
- (3) Advocacy; Assistance for Recovery and Self-Determination;
- (4) Support for Consumer and Family Advisory Councils;
- (5) Information and Education;
- (6) Resolution of Complaints and Appeals:
- (7) Support of Consumer Initiatives;
- (8) Marketing and Public Relations;
- (9) Recipient Rights Education, Investigation of Complaints;
- (10) Rights Protection.

8.2 Conflict of Interest

The Contractor's organizational structure shall include a clear separation of the Customer Services function from Utilization Management, Finance and Provider Services to ensure appropriate firewalls relevant to complaints, disputes, appeals and grievances.

Staff assigned to investigate complaints and alleged rights violations shall not participate if prior activities in the same case could compromise the investigation.

8.3 Staff

Customer Services Specialists shall be identifiable to consumers knowledgeable about all aspects of the Contractor including access, benefits, eligibility, authorizations, claims, protocols, and other rules and regulations. The Specialists are an important link between the internal and external customers of the Contractor.

Staff shall provide support to the Contractor Governing Board's Human Rights Committee (T10A 14V.0504). Staff shall provide support to the Contractor Consumer and Family Advisory Committee (CFAC).

There shall be an identifiable Consumer Rights Officer

The Contractor shall provide the appropriate personnel to establish implement and maintain the necessary functions of the local complaint and appeal process. The staff and the office site shall be identifiable to the public.

Staff shall be sensitive to a consumer's need for information about pending grievances and complaints and shall contact the consumer at frequent intervals to update them on the status of any issue they have reported to Customer Services.

Should issues relating to the decisions and actions of the Contractor, which involve provider grievances, appeals or requests for hearing, rise to the level of administrative hearing and/or judicial review, the Contractor shall provide the necessary professional, paraprofessional and clerical services for the representation of the Contractor.

8.4 Information and Dissemination of Materials

The Contractor shall produce and provide printed information (including a consumer information handbook) regarding its organization, services and system for filing complaints and appeals within ten (10) days of enrollment to each consumer or enrolled person's family. Printed information materials shall be provided to consumers when there are program provider changes or service site changes, at least fourteen (14) days before implementation.

The Contractor shall publicize the phone number and location of designated access points. The Contractor shall provide information and education to the general public about MH/DD/SA disorders and how to access services.

Outreach shall occur for vulnerable and at-risk populations. Routine screening shall occur for common MH/DD/SA disorders The Contractor shall provide outreach activities designed to inform consumers and potential consumers of the availability of MH/DD/SA services in accordance with DHHS policies on outreach. The Contractor shall utilize penetration rates and other quality management measures to assess the effectiveness of these outreach efforts.

All printed information and materials for enrolled persons prepared by the Contractor shall be reviewed by CFAC prior to distribution.

The Contractor shall ensure that consumer handbooks are available at all provider sites and easily accessible to all enrolled persons at anytime. The Contractor shall make available upon request, copies of the handbook to known consumer and family advocacy organizations and to other human service organizations in its geographic service area. The Contractor shall include the following minimum information in the Handbook:

- (1) An explanation of financial responsibility and the coordination of third party benefits; including list of any applicable co-payments, a statement that care to enrolled persons who have a serious and persistent mental illness or children with a serious emotional disturbance or Medicaid enrolled persons shall not be denied care due to lack of co-payment. The Handbook shall clearly state that enrolled persons cannot be billed for covered services (other than applicable co-payments) and under what circumstances an enrolled person may be billed for non-covered services;
- (2) Assistance for enrollees moving out of the Contractor area and the procedure for referral and records release;
- (3) The policy regarding confidentiality and confidentiality limitations;
- (4) Information that coordination of care with schools and State agencies may occur, within the limits of applicable regulations;
- (5) Empowering actions and contributions the enrolled person can make toward his or her own wellness, recovery, and supports including responsibilities in treatment, and Contractor/QPN Codes of Conduct;
- (6) A description of the Fair Hearing Rights available only to Medicaid recipients in accordance with federal regulations at 42 CFR 431, Sub-Part E;
- (7) A description of the consumer's rights in G.S.122C Article 3;
- (8) A description and the Contractor's complaint and appeal system;
- (9) A description of PCP and what to expect when one is developed;
- (10) An explanation that the enrolled person or guardian is required to sign a consent to treat form, which includes permission for DHHS to access information in the MH/DD/SA record:

- (11) An explanation that the sharing of MH/DD/SA record information with the Primary Care Physician (PP) of enrolled persons for coordination of care will occur within the limits of applicable regulations;
- (12) A list of addresses and toll-free numbers for State and local advocacy and support groups including the State Advocacy and Customer Services Section and the Governor's Council for Persons with Disabilities (GACPD);
- (13) Complaint and Appeal descriptive information regarding alleged rights violations, access to services, authorization for services, treatment and quality disputes.
- (14) The process for a standardized written notification for reduction, denials, suspensions, or terminations of services provided to consumers with and without Medicaid eligibility, on a standardized form as dictated by DHHS.
- (15) A statement to encourage all consumers to resolve disputes informally with providers without discouraging access to formal complaint and appeal procedures;
- Information that explains how to file a complaint and appeal and/or request for a Fair Hearing (Medicaid recipients only) at the Office of Administrative Hearings (42 CFR 431 Sub-Part E, G.S. 150 B) process, including: Contact information for the Contractor customer services staff; and the Office of Administrative Hearings; Time limitations for submitting complaints and appeals and Fair Hearings requests to the Office of Administrative Hearings; Information about the circumstances in which the enrolled person has a right to receive services throughout the complaint, appeal or request for Fair Hearing; A statement that retaliation cannot occur if an enrolled person files a grievance, appeal or request for hearing;
- (17) Instructions for receiving care in case of an emergency, both inside and outside the enrolled person's normal service area and proper emergency service utilization and how to access after-hours care, ensuring a proactive approach to care and support.
- (18) In medical emergencies, the Consumer Handbook shall instruct enrolled persons to use the emergency medical services (EMS) available and/or activate EMS by dialing 9-1-1- in a life-threatening situation, but not as a substitute for Contractor related emergencies;
- (19) How to obtain emergency transportation and non-emergency medically necessary transportation for enrolled persons;
- (20) A statement that includes priority access to substance abuse treatment for pregnant women requiring such services;
- (21) A description of fraud and abuse, including instructions on how to report suspected fraud or abuse.
- (22) Instructions for obtaining culturally competent materials, including translated materials and a list of providers who speak languages other than English.
- (23) The last revision date.

8.5 Complaints and Appeals

The Contractor shall comply and assure compliance of its QPN with all grievance/appeal rules and policies/procedures as may be established by DHHS and attached to this Contract in Attachment III-9. Written policies and procedures shall be in accordance with applicable federal and State law, DHHS Policies and Procedures, and additional policies, which may from time to time be revised. The Contractor shall ensure the continuation of current authorized services during the appeal process pursuant to that specified in State or Federal laws, rules and DHHS policy. The Complaint /Appeal/Request for Hearing process may not be delegated or subcontracted.

The Contractor shall approve informal complaint and appeal processes established by providers. A consumer shall not be required to exhaust a provider's informal complaint and appeal process before filing a formal complaint with the Contractor.

DHHS may review the Contractor's formal and provider informal policies and procedures regarding complaints and appeals processes.

The Contractor shall ensure that any services specified in a MH/DD/SA Appeals Panel decision are promptly provided, whether or not a petition to the Office of Administrative Hearings is filed (G.S. 122C-151.4) (G.S. 150B)

The Contractor shall have a written policy and procedure for complaint and appeal, and request for hearing policies for providers that define their rights regarding any adverse action or decision by the Contractor.

8.6 Self-Help

The Contractor shall assure that support and self-help is available to people before, during and after enrollment in the MH/DD/SA system.

The Contractor shall provide a broad array of programs focused on preventing MH/DD/SA disorders. The following are examples of programs provided: Stress Management Workshops: Early Detection Programs such as National Depression Screening Day, National Anxiety Disorder Screening Day, National Eating Disorder Screening Day, ADD/ADHD Screening Day and Depression Screenings for the elderly.

8.7 Customer Satisfaction Plan

The Contractor shall have an annual Customer Satisfaction Plan. The primary purpose of the plan is to obtain input from external stakeholders, internal stakeholders, and the ultimate customer. A variety of means may be used to solicit feedback, including but not limited to satisfaction surveys, focus groups, public hearings, liaison contacts, face-to-face interviews and interviews/surveys conducted by other third parties.

8.8 CFAC and Human Rights Committee (HRC)

The Contractor shall have a CFAC and a Human Rights Committee (HRC). The Contractor may choose to support other advisory committees such as a Research Advisory Committee. The Contractor shall have a clear and accommodating process for applying to be a member of such committees. The Contractor shall also maintain policies and procedures to support Consumer and Family involvement including the payment of stipends, transportation, respite care, training, etc. There shall be written guidelines and plans for each committee that describes their functions, authorities, rules and processes.

A designated Customer Services staff member should be assigned as support to each committee. Support activities shall be defined in advance. Staff support includes making resources available, breaking down barriers, providing data and information requested in advance, and being a resource for questions about the Contractor and its policies and procedures. The support staff does not make decisions and requests the committee to ask for decisions via formal mechanisms established by Contractor policy and procedure. Committees generally conduct the following activities:

- (1) Set and carry out an Agenda
- (2) Study and evaluate services (either treatment services or other Contractor provided services such as Customer Services)
- (3) Analyze and review feedback from Customer Satisfaction data
- (4) Advocate for better/improved programs and services
- (5) Identify gaps in services
- (6) Identify trends in data that indicate a need for improvement
- (7) Support the exchange of information
- (8) Review and comment on public policy
- (9) Make recommendations to the CEO for development or enhancement of services

8.9 Reporting

The Customer Services section shall prepare a written report of data monthly regarding:

- (1) The number of adequate or advance notices or adverse Actions;
- (2) The number of complaints, disputes, grievances and appeals by category;
- (3) The timeliness of response and other data necessary to measure the effectiveness of the customer services process.

This data should be available to the general public as well as to Boards, Advisory Committees and in the customer services department upon request. The data shall be used by QI for making improvements.

8.10 Client Rights

The Contractor shall have a Policy and procedures that implements the Rights functions of the organization and protects the rights of consumers in compliance with legislation, Administrative Rules, and the mandatory reporting provisions of Protective Services Acts (GS). The Contractor shall provide sufficient funding and staffing to fully implement the Policy and procedures. The Rights policy and procedures shall contain the following:

- (1) Clearly articulated policies that define Rights and what constitutes a Rights Violation.
- (2) Definition of the responsibility and authority of the local rights specialists.
- (3) A mandatory reporting Policy in its provider contracts. The provider contract shall also stipulate compliance with findings of the Contractor rights specialist.
- (4) A requirement that information regarding rights shall be available to all applicants and recipients of services, parents, guardians, and others. Informational materials shall be available in all service locations.
- (5) A requirement regarding rights education, including that orientation sessions shall be required for all new Contractor employees, QPN employees, volunteers, and students. Additional training shall be provided, as requested by staff, network providers, recipients, members of the community and others.
- (6) Requirements for formal complaints, including reports of suspected or apparent violations of rights within the QPN shall be investigated according to established criteria and those, which do not meet criteria for investigation, shall be acknowledged. When indicated, investigations shall be coordinated with the DHHS, Protective Services, and law enforcement.
- (7) A system for informal Complaints/Interventions: A system shall be defined by the Contractor to receive concerns and inquiries by referral and when appropriate to utilize informal intervention to obtain a remedy on behalf of the recipients involved.
- (8) A review of Critical incidents: The Contractor rights specialist shall review all critical incidents, including any deaths of consumers residing in 24-hour care and supervised settings and any death of active consumers who commit suicide. Reports of Critical incidents shall be communicated to the Chief Executive Officer, the Board, and to the State. The Contractor shall compile data on the number and type of rights violations and other critical incidents, those that are resolved informally, findings pursuant to an investigation and provider compliance with mandatory reporting.
- (9) Requirements for the Human Rights Committee: The HRC shall serve as the Appeals Committee for Recipient Rights. The HRC shall also review aggregate rights data and critical incident data for trends and shall make recommendations to the Executive Director that may include additional training or sanctions for providers that demonstrate a pattern of disregard for the rights of clients.

(10) A Code of Conduct shall be posted in all reception areas. Sanctions for client violation of the Code of Conduct shall be incorporated in the individual's PCP. Discharge from service for a violation shall occur only upon the recommendation of the Human Rights Committee.

8.11 Consumer Owned and Operated Businesses

The Contractor shall be committed to consumer driven service delivery. As a result of this commitment, the Contractor shall help develop several consumer owned, run and/or delivered services such as:

- (1) Consumer Run Support Groups
- (2) Consumer Run Drop-In that can provide a variety of consumer-delivered services and supports including Peer Support Advocates, Recovery Trainers
- (3) Consumer Person Centered Planning Facilitation
- (4) A consumer-run Friendship Phone Line
- (5) Mystery Shopper Programs.

8.12 Employment of Consumers

The Contractor shall include the employment of consumers in its affirmative action plan. Provider contracts may stipulate the employment of consumers in certain key positions.

9.0 Quality Improvement & Outcome Evaluation

9.1 Responsibility

The Contractor shall develop and implement a quality management system to meet State Plan requirements that includes practices of annual strategic planning, quality improvement and quality assurance. Consumers and family members shall be meaningfully involved in QM efforts at all levels of the system in accordance with criteria outlined in the State Plan.

9.2 Quality Management (QM) Plan

The Contractor shall have a QM plan that is understandable to all stakeholders and shall insure that members of the QPN maintain a Plan that has similar key components. The purpose of QM is to effect ongoing improvements in the delivery and administration of services in order to improve outcomes for persons served with identified mechanisms for translating the knowledge gained through QM into changes in practice that can reasonably be expected to result in improved outcomes. The plan shall include a:

- (1) Statement of philosophy of quality management;
- (2) Description of the scope of quality management activities;

- (3) Description of staff and other resources dedicated to quality management;
- (4) Description of an internal structure for ensuring leadership and commitment to quality management within the Contractor's organization;
- (5) Systematic processes to:
 - (a) Collect manage and review data on system performance, service outcomes, and customer satisfaction with services
 - (b) Identify and prioritize opportunities for improvement
 - (c) Design and approve improvement projects
 - (d) Implement changes and evaluate results
 - (e) Reward efforts and successes
 - (f) Focus improvement efforts on achievement of the goals in the strategic plan
 - (g) Identify ways to foster a culture of quality improvement within the Contractor organization and QPN
 - (h) Mechanisms for securing meaningful involvement of consumers and families (ultimate customers), staff (internal customers), and key external customers in QM activities:
 - (i) Mechanisms and resources for collection, management, analysis and dissemination of data including but not limited to:
 - (i) Critical incidents
 - (k) Complaints
 - (I) Service over and under utilization
- (6) Performance measures including consumer satisfaction measures and consumer outcomes measures
- (7) Mechanisms for evaluating the effectiveness of specific improvement projects and the Contractor internal quality improvement system
- (8) Procedures for updating the Quality Management Plan
- (9) Mechanisms for staff and customer training in QI philosophy and methods

9.3 Quality Improvement (QI)

QI shall include internally generated self-evaluation and improvement efforts to ensure continuous progress toward meeting optimal standards as determined by the needs of consumers, families and stakeholders and the mission, vision and values of the State Plan. The QI system fosters a culture of Continuous Improvement through education, training, technical assistance, and ongoing self-evaluation and evaluation of the needs of the community.

The Contractor shall have a Local Quality Improvement Committee (LQIC) for modeling and implementing Continuous Quality Improvement philosophy and techniques within the Contractor network. The Committee is responsible for performing a specific set of quality improvement activities and addressing service quality issues that emerge within the local system:

(1) The Local Quality Improvement Committee (LQIC) shall be constituted by the Contractor from a slate of interested stakeholders, including

- consumers, family members and providers in accordance with the Contractor QM Plan. The LQIC shall have a clear, written process for membership and participation on the committee; including clear, written guidelines for internal operating procedures that support the QI philosophy; guided by the values of full and meaningful participation, mutual understanding, inclusive solutions, and shared responsibility.
- (2) Routine activities of the Committee shall include reviewing, analyzing and interpreting: Consumer Satisfaction data, Client Rights Committee Reports, Consumer Outcomes data, Performance Measures data, Utilization Management data and other data that are collected on a regular basis. The QIC shall accept suggestions for improvement, prioritize QI efforts, perform a root cause analysis on identified issues collecting input and data to determine if the issue is systemic or isolated and refer matters to responsible parties for resolution.
- (3) The Committee shall make recommendations to the Contractor for solutions to the problems that emerge and follow up to determine if improvements result from whatever action is taken on its recommendations.

9.4 Quality Assurance (QA)

QA shall include monitoring of externally imposed requirements for system operations to ensure that efforts meet minimum standards of service provision, protection of consumer rights, and fiscal responsibility.

The Contractor shall use monitoring efforts and resources efficiently and effectively to ensure that the services provided in the catchment area are adequate, appropriate and of good quality:

- (1) The Contractor shall assess provider compliance with minimum performance standards using a schedule of monitoring frequency and intensity applicable to each provider;
- (2) The Contractor shall utilize clear measures of the performance goals with minimum and target standards and definitions of how compliance with standards will be determined;
- (3) The Contractor shall have a systematic process for ensuring the prompt correction of problems with consequences for non-compliance with minimum standards and a procedure for action if the safety of consumers is at immediate risk;
- (4) Receive, review, analyze, respond to and report on critical incidents
- (5) Monitor timeliness standards and access to service;
- (6) Review, analyze and report on complaints concerning the provision of services
- (7) Monitor the compliance of 122C-licensed and unlicensed service providers with Federal and State laws, regulations and performance standards;

- (8) Monitor fidelity to best practice models and the attainment of desired individual outcomes, while encouraging deliberate, research-driven innovation and emerging best practice models.
- (9) Review data collection for usefulness and cost/benefit assuring integration with the information management system to produce real time reports and maintain compliance with state and federal data as required for NC TOPPS; NC SNAP; SAMSHA admission and discharge data; SASHA TEDS and CSAP MDS for prevention;

The Contractor shall produce, at least annually, Provider Management Reports and Provider Profiles that evaluate providers in the network against target performance goals, compliance with minimum standards, utilization patterns, customer satisfaction, accessibility, costs and licensing/accreditation status. The Contractor shall make reports available to DHHS, consumers and the general public. The Contractor shall use the reports for guidance in re-credentialing, quality monitoring, contract management, and to assist consumers in making informed choices about provider selection.

The Contractor shall establish a process for monitoring the credentialing of Contractor staff and staff employed by the QPN.